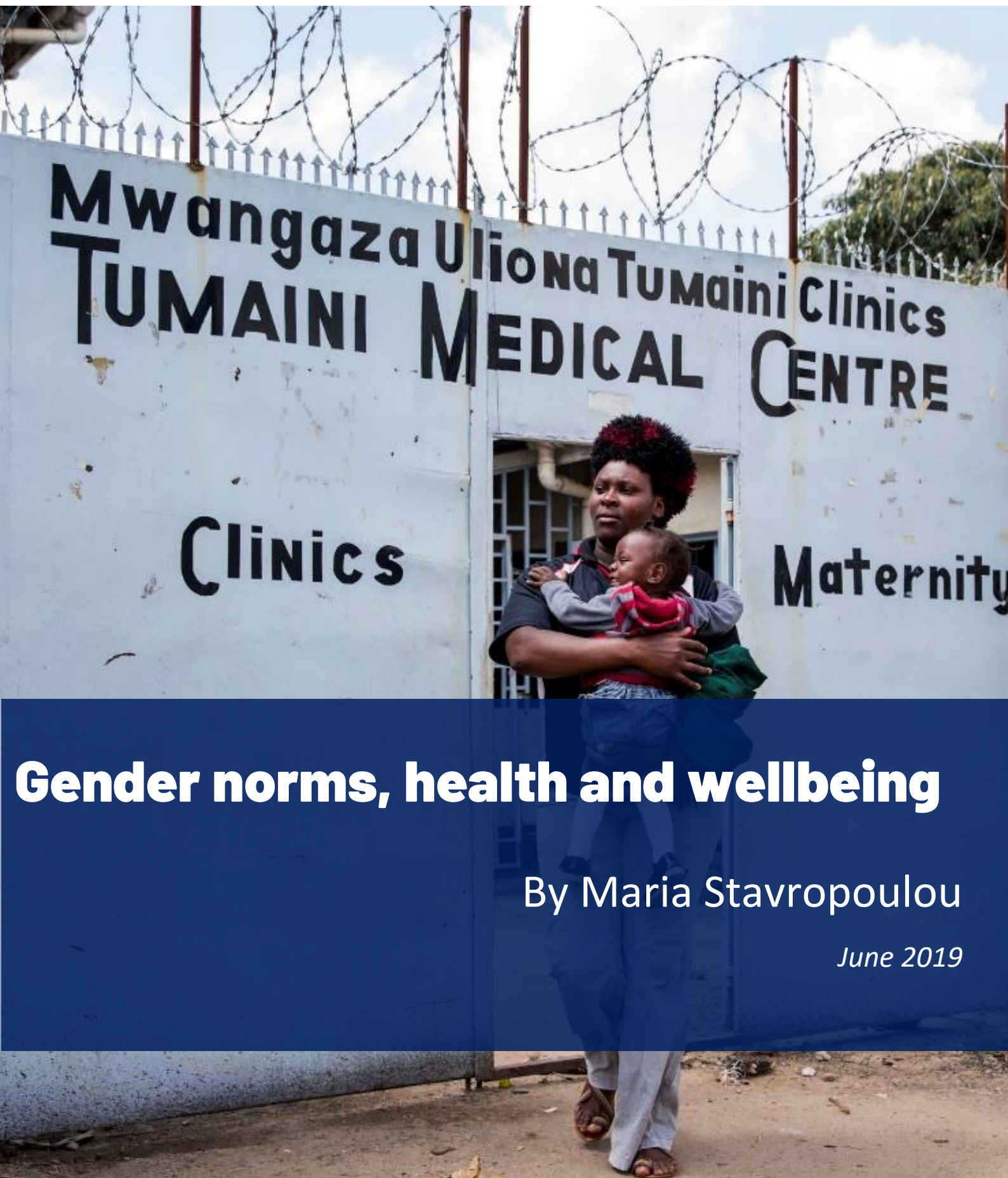


ALIGN

Advancing Learning and
Innovation on Gender Norms



Gender norms, health and wellbeing

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1. Introduction

Gender norms are informal, often implicit rules of masculinity and femininity that guide people's attitudes and behaviours. Their strong influence can harm the health and wellbeing of women and men, girls and boys in many ways, particularly by exposing them to different health risks, distorting the recognition of their health needs and embedding disparities in their access to health care.

This thematic guide brings together key evidence on how discriminatory gender norms affect health outcomes for adolescents and youth in low- and middle-income countries (LMICs). While there are several definitions of these age groups, this guide follows the [United Nations and WHO definition](#) according to which adolescents include persons aged 10-19 years and youth those between 15 and 24 years. It focuses on adolescence as a critical stage of life – a stage when many behaviours that will have a significant impact on adult health and wellbeing, begin or are consolidated. Adolescents account for a substantial proportion of the global disease and injury burden, with more than two-thirds of all adolescent deaths occurring in LMICs.

The current [call for action on the health of adolescents and youth](#) is a unique opportunity to identify and respond to their particular health needs. Although the role of gender inequality and the norms that reflect and reproduce it are often neglected, they shape boys' and girls' understanding of what is acceptable and appropriate. As such, they are clearly part of the problem and should also be addressed in both policy and programming to improve adolescent and youth health.

This thematic guide presents key evidence on the ways in which discriminatory gender norms affect the vulnerability of adolescents and youth to major health and wellbeing problems, including:

- non-communicable diseases
- communicable and infectious diseases
- poor nutritional status
- threats to physical integrity: violence, body modification and unintentional injuries
- sexual and reproductive health risks and infections
- challenges for mental health and psychosocial wellbeing
- and the gendered responses of health systems.

The guide aims to share existing knowledge and raise awareness among researchers and practitioners of the significant, yet often invisible role, played by gender norms in heightening health risks and vulnerabilities, limiting the responses of health systems and ultimately damaging the health and wellbeing of adolescents and youth in LMICs. Given the scale of the current knowledge gaps in LMICs, however, the guide also presents some relevant evidence from high-income countries (HICs).

This guide will be followed by information on best practices and promising initiatives to address harmful gender norms and promote adolescent and youth health.

Setting the scene: key concepts

According to WHO, gender is a [key social determinant of health and wellbeing](#). While sex and gender are often used interchangeably in medical literature, they are very different. Sex refers to the biological and physiological differences between women and men such as chromosomes, hormones or genitalia. Gender, however, refers to the socially-constructed characteristics, behaviours and roles of women and men.

Gender has, therefore, five main elements: relational, hierarchical, historical, contextual and institutional. Gender relations refer to the relations between women and men. They often [create hierarchies between and among groups of women and men](#) that lead to unequal power relations disadvantaging one group over another. Most societies give men privileged access and control over rights, resources and opportunities and value masculine attributes, roles and behaviours more highly than those associated with women and femininity.

Norms have been called '[the vital determinants](#)' of social hierarchy as they reflect, reproduce and normalise relations of power. Gender norms, in particular, dictate what is masculine, what is feminine and how men and women should behave in their daily lives, promoting those behaviours as natural and thus legitimate ways of being and doing in a given context.

Gender norms can [harm the health and wellbeing](#) of women and men, girls and boys through multiple pathways. They shape differential exposure to health risks, differential acknowledgement of health needs and differential access to health care. Gender norms, however, are not static but can be negotiated, challenged and changed, and their harmful effects on health can be prevented or mitigated.

In 2007, [a ground-breaking paper](#) by the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health synthesised knowledge about the health outcomes of unequal gender relations. Authors Sen, Östlin and George argued that 'Sex and society interact to determine who is well or ill, who is treated or not, who is exposed or vulnerable to ill-health and how, whose behaviour is risk-prone or risk averse, and whose health needs are acknowledged or dismissed' (2007: xiii).

Their influential framework set out the factors that determine gender inequities in health. In particular, they identified four main causal pathways:

- discriminatory values, norms, practices and behaviours
- differential exposures and vulnerabilities to disease, disability and injuries
- biases in health systems
- and biased health research.

They also emphasised that gender interacts with other forms of social disadvantage such as those linked to socioeconomic class, race, ethnicity or caste, disability, age and stage in the lifecycle to accentuate health inequities. Those who do not conform to established gender norms, including those who do not follow 'acceptable' patterns of sexual orientation, may also face stigma, discrimination and poorer health outcomes.

While [Sen et al. \(2007\)](#) discuss how gender inequality damages human health, the past decade has also seen the emergence of adolescent health and wellbeing as a top priority on the global agenda. There are two main reasons for this: first, [adolescence is a critical stage of human](#)

[development](#) during which many health behaviours are acquired that may have lifelong consequences. Second, recent [epigenetic and neurodevelopmental findings](#) indicate that the adolescent brain is still developing and is much more plastic than previously believed, providing an opportunity to intervene at a pivotal moment and shape healthier behaviours. Current research is focusing on a better understanding of the transition to adulthood as adolescents start to learn, experiment with, conform to or challenge gender norms and related behaviours and roles that will influence their health and their lives.

There is a growing focus on the role of gender norms on health, as shown by the [increasing number of studies](#) that explore how gender inequality and gender norms affect health and the quality of life for all. Studies from different disciplines have also analysed the role of unequal gender relations on health conditions and outcomes ranging from infectious diseases to mental health problems and from nutrition to injuries. Recent studies have looked more closely at the role of discriminatory gender norms in relation to intimate partner violence and sexual and reproductive health.

This guide will explore the pathways through which gender norms shape key health behaviours and outcomes, building on the framework developed by Sen et al. (2007) (see Figure 1). We will focus in particular on the first three pathways they identified through which gender norms affect health and wellbeing:

- gender norms, values, practices and behaviours
- gender norms and exposure and vulnerability to disease
- and gender norms and health systems.
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1.1 Pathway 1: Gender norms and values, practices and behaviours

Gender norms shape values, practices and behaviours that matter for health and wellbeing because they determine knowledge and attitudes about health and healthcare. In particular, they influence access to health information, the perceived value of the individual and their power to make decisions about their own health, risk-averse or risk-prone behaviours, health-seeking practices and access to health services.

Gender norms can damage the health and wellbeing of women and girls, as well as men and boys. In many societies, [norms associate masculinity](#) with strength, toughness, independence, self-reliance and risk-taking. Older adolescent boys and young men tend to engage in excessive alcohol consumption, unprotected sex, dangerous driving or violent practices and have higher rates of substance abuse, injuries from traffic accidents and homicides. Girls and young women, however, are often seen as more vulnerable and risk-averse and are expected to [show modesty, submission and dependence](#) while their movements are restricted and monitored and their sexuality is controlled. As a result, adolescent girls and young women tend to have lower levels of physical activity and are more likely to experience violence or suffer depression.

Gender norms on acceptable behaviours also influence the health-seeking practices of young men and women. Sickness, the expression of pain and asking for help are linked to weakness and vulnerability that contradict the masculine ideal. Men feel pressure, therefore, to [dismiss their health care needs](#), display strength and avoid or delay seeking health care. Women tend to

be more likely to seek help for physical and mental health problems, yet they are also expected to be [self-sacrificing](#) and put the needs of other family members before their own health.

Because prevalent norms about feminine and masculine behaviours regulate access to health care, they often have harmful consequences for those who do not adhere to them. Adolescent girls who become pregnant outside marriage, for example, might not seek reproductive health services because of perceived stigma. In gender-segregated contexts with restrictive norms that emphasise female modesty and purity, 'good' [girls and women can only move in public spaces if accompanied by a male guardian](#) and must never be examined by male health providers as this would violate established rules about acceptable interaction between genders. Similarly, [men who do not conform to the masculine heterosexual ideal](#) may avoid seeking health care for a sexually transmitted infection (STI) to avoid discrimination and humiliation.

Most importantly, access to health services is linked to the relative 'worth' of girls and women versus boys and men, and to unequal access to household resources, authority and decision-making. Evidence across LMICs shows that gender inequality privileges the health and wellbeing of boys and men, especially in settings characterised by a strong preference for sons. One extreme expression of this gender bias is the persistent [excess mortality of girls](#) as a result of prenatal sex selection and postnatal discrimination in some countries, especially in South and East Asia.

Women and girls often lack resources and decision-making power. They depend, therefore, on male members of their household to access the health services they need and to pay for transportation and medication. Adolescent girls, in particular, need the consent of their parents or spouse to access health services. Studies have found, however, that [men often lack the necessary health knowledge](#) and are unwilling to spend money on the health of women and girls, with some evidence suggesting that they spend a greater share of household resources on their own health needs or those of their sons. The end result is that women and girls delay accessing the care they need, have difficulty in completing treatment, or are forced to use informal healers and their therapies.

1.2 Pathway 2: Gender norms and exposure and vulnerability to disease

Gender norms and roles also shape disparities in exposure and vulnerability to health risks and disease. While [biological sex differences interact with gender](#) and other social determinants to increase vulnerability to disease (e.g. HIV infection for women), gender roles and responsibilities also expose men and women, boys and girls to health risks in different ways in both the workplace and the household.

In many settings, [men and women tend to dominate tasks and occupations](#) that are seen as suitable for their bodies and their gender roles. Men, therefore, undertake more physically intensive work and account for most workers in construction, transportation, fishing and fire-fighting, while women are concentrated in caring and service professions or light assembly work.

This gender segregation in the labour market exposes men and women to [different physical and psychosocial risks and hazards](#). Men have more occupational accidents than women and are more exposed to noise, vibration, extreme temperatures, chemicals or the long-term

impact of heavy lifting and carrying. Women, however, are more exposed to highly repetitive and monotonous work, poor postures, and increased stress and sexual harassment and violence. Those working in cash crop production, in particular, are exposed to pesticides and toxic chemicals. More women than men report musculoskeletal problems, repetitive strain injury, work-related fatigue, adverse reproductive health outcomes, infections and mental health problems.

There is also a gender division of labour within the household, with women and girls expected to shoulder most domestic and care work, [leaving them little or no time](#) for other activities. Indeed, [data from 83 countries](#) show that women spend 18% of their day on unpaid domestic and care work, compared to 7% for men, doing 2.6 times more unpaid domestic and care work than men. Women aged 25–44 who have young children allocate more time to their care than any other female age group. Similarly, [data from 33 countries](#) indicate that girls aged 7–14 do more household work than their male peers while also having to care for younger siblings.

In 2013, a [report](#) by the UN Special Rapporteur on extreme poverty and human rights to the UN General Assembly acknowledged unpaid care work as a major human rights issue. It stressed that women's unequal and heavy care responsibilities are a major barrier to gender equality and to women's enjoyment of rights, exacerbating inequalities and threatening their wellbeing, including their right to health.

Globally, when unpaid work is included, women work longer hours than men, and their burden increases with poverty and social exclusion: women and girls in poor households in all countries spend more time on unpaid care because of lack of resources, basic services, adequate infrastructure and time-saving technology. The report points out that there are limits to how much care a person can provide without harming her own health as domestic and care work can be stressful, difficult or even dangerous, exposing women and girls to diseases, violence, burns or injuries.

Women and girls are also responsible for collecting water and fuel for domestic use. These tasks demand a lot of time, undermining opportunities for women and girls in terms of education and income-generation and their chance to rest.

National survey data show that they are [responsible for water collection](#) in 80% of households without access to clean water on the premises, with women and girls in the poorest rural households travelling longer distances and spending more time to reach water sources. A study of [survey data in 24 sub-Saharan African countries](#) estimated that girls are more likely than boys to be responsible for water collection in households that spend more than 30 minutes each day on this task: 62% versus 38%. Similarly, they are more likely to gather fuel wood, with girls in households that rely on it for cooking spending [18 hours each week](#) on its collection.

Gathering water and fuel is also physically demanding. Women and girls often walk long distances with loads of wood, dung or other fuels that weigh 40 kg or more on their backs or heads. These tasks expose them to [a range of risks](#) such as spinal conditions and chronic headaches, injuries, animal attacks and violence.

Gender roles and expectations about what women and men can and should do in specific contexts can also contribute to gender morbidity and mortality in natural disasters. An [analysis of data](#) from 141 countries found that women and girls are more exposed to disaster risks and

are more likely to suffer higher rates of morbidity and mortality than men and boys in disasters because of their reduced ability to save themselves. Gender norms restrict their movements, as well as their access to information and warnings, and their limited skills and coping strategies only increase their vulnerability to such catastrophic events. In Sri Lanka, for example, men were more likely to survive during the tsunami because they knew how to swim and climb trees.

The study stresses that the higher the women's socioeconomic status, the weaker the impact of disasters on the life expectancy gender gap. While women are more likely to die than men during natural disasters in places where they do not enjoy the same economic and social rights as men, disasters cause the same number of deaths among men and women where they enjoy equal rights.

1.3 Pathway 3: Gender norms and health systems

While exploring this third pathway, [Sen et al.](#) (2007) stressed that health systems do not only produce health care, but also reflect, convey and reinforce societal norms and values. [Health systems are not gender or power neutral](#): their main components, such as service delivery, human resources, health financing or governance, are affected by entrenched gender norms that often compromise their effectiveness.

[Health providers](#), for example, may reproduce gender stereotypes and provide different care for men and women who are suffering from the same health problem. They may discriminate against or even abuse those who do not adhere to gender norms or refuse male involvement in health programmes for women. Female health providers are also more likely to find it difficult to advance their careers.

Many health systems continue to neglect gender and the ways in which gender relations shape access to resources, roles and responsibilities and decision making. They fail to acknowledge the different health needs and problems of both women and men and, therefore, fail to provide the health services they require.

2. Non-communicable diseases and gender norms

A number of health traits that often emerge during adolescence have been identified as leading risk factors for non-communicable diseases (NCDs) in later life. They include low physical activity, overweight and obesity, air pollution, and the use of tobacco and alcohol. Public health experts tend to discuss these as individual behaviours that threaten health outcomes in adult life without always focusing on how they are shaped by gender norms.

2.1 Low physical activity

Regular physical activity has major health benefits, yet global data indicate that [81% of adolescents have lower than the minimum recommended levels of activity](#), with adolescent girls less active than boys. Worldwide, 84% of girls compared to 78% of boys were insufficiently active in 2010, and girls become less active as they grow older. Data from the 2013/2014 Health Behaviour in School-aged Children ([HBSC](#)) study show that physical activity decreases considerably among girls age 11 to 15 in most countries, with boys being far more active. While the relationship between gender norms and physical activity in adolescence needs further

research, there is evidence that gender norms affect girls' engagement in physical activities in the following ways, with variations across contexts.

Norms about feminine and masculine bodies and attributes

[A scoping review](#) of literature on high-income settings concluded that the relationship of adolescent girls with physical activity is complex, is dominated by discussions of the female body and requires the negotiation of gender roles and stereotypes. Although girls report that they enjoy physical activity, given its many benefits (such as increased self-esteem, improved health and better social relations), they often find it difficult to reconcile being feminine with being athletic and doing activities usually associated with boys.

Girls may, therefore, be more likely to take part in physical activities such as dance and gymnastics than boys, who often prefer football or hockey. Girls may also be concerned that such physical activities could make them look less feminine and more aggressive or muscular to their peers or even appear to be [challenging heterosexual normative ideals](#), provoking criticism or rejection. Girls may also believe that some qualities promoted by physical activity, such as competitiveness and strength, are incompatible with traditional feminine ideals.

Another [global review](#) also noted that physical activities in schools are often dominated by sports that promote aggression and competitiveness. Traditional norms may be reinforced by teachers and peers through the exclusion of girls and the stigmatisation of boys who cannot conform to masculine stereotypes.

Norms about mobility and safety

In conservative contexts where the mobility of girls and young women is restricted and male guardians – parents or spouses – decide where they can go, they tend to stay indoors. As a result, they cannot engage in physical activity in public spaces as this could damage their own reputation and that of their family. Such restrictions in parts of South Asia and the Middle East and North Africa (MENA) discourage them from taking part in physical activity during their leisure time and promote a sedentary lifestyle.

In recent years, however, international bodies, governments and civil society have [supported girls' right to physical education](#). They have also implemented programmes in safe spaces that combine physical activity and sports with life-skills training to empower girls and tackle the norms that constrain their lives and undermine their wellbeing.

2.2 Overweight and obesity

In 2016, almost 340 million children and adolescents aged 5–19 years worldwide [were overweight or obese](#) – almost one in every five. While HICs still have the highest prevalence rates, obesity rates for this age group are increasing much faster in LMICs. Higher socioeconomic status has been identified as a risk factor for childhood and adolescent obesity in many countries, including [countries in the MENA region](#).

Gender norms and context appear to influence diverse dietary habits, from over-eating to extreme dieting. [Two studies](#) that combined comparable obesity prevalence data with indicators of gender inequality (such as the Global Gender Gap Index and the Gender Inequality Index) concluded that gender disparities in obesity prevalence are larger in countries with greater gender inequality.

Norms about feminine and masculine bodies and attributes

Globally, a [higher proportion of boys](#) are obese than girls. However, girls have a higher prevalence rate in Africa. In [South Africa](#), two-thirds of black girls perceived fatness as a sign of happiness and wealth and saw themselves as attractive. In [some Pacific islands](#), female thinness is associated with illness and infertility.

[Gender disparities in obesity](#) are also high in the MENA region, where some societies favour larger body sizes as a sign of fertility, good health or prosperity, while also constraining women's mobility and their participation in physical activity. A [study](#) on dietary habits and physical activity among adolescents aged 15–18 in seven countries in the region found significant gender differences on perceived barriers to physical activity. Girls were more likely than boys to report personal, social and environmental barriers, including lack of motivation, support from parents and teachers, access to spaces and cultural norms prompting them to do so – in all countries between 40% and 81% of girls identified cultural factors to be important or somewhat important barriers to physical activity compared with 7% and 37% of boys.

2.3 Tobacco use

Tobacco use is a major risk factor for NCDs, including breathing difficulties and asthma among youth and cancers among adults. In 2016, [more than 1.1 billion people](#) aged 15 years and older smoked tobacco. Globally, men and boys have a far higher prevalence of smoking than women and girls (34% of men compared to 6% of women).

Tobacco is often the first substance used by youth who start smoking in early adolescence. [WHO](#) estimates that there are 24.2 million smokers aged 13–15. [Globally](#), one in every five boys aged 13–15 years and one in every ten girls of the same age uses tobacco. Prevalence rates are highest in Europe and lowest in Africa and Asia, with significant variations within regions. Most importantly, [rates of young smokers](#) are declining in HICs, but are increasing in lower middle-income countries. In addition, 13 million adolescents aged 13–15, more boys than girls, use smokeless tobacco products, especially in South-East Asia and in lower middle-income countries.

Norms about masculine and feminine behaviours

In many contexts, [tobacco use](#) has been an integral part of social and ritual life and, because men are more likely to dominate such activities and smoke, it is seen as a male attribute. Smoking has often been perceived as [unfeminine and immodest](#) and women (with the exception of elderly women) are discouraged from smoking, at least in public. However, social constraints that prevent women smoking have weakened in HICs as their autonomy and economic independence have increased, leading to high rates of smoking among women and girls.

The [reasons for smoking vary by gender](#): its association with masculinity and sexual attractiveness may motivate adolescent boys and young men to smoke, together with peer pressure and exposure to tobacco marketing – all cited as factors that influence male tobacco use. Girls and young women, however, may equate smoking with empowerment, independence, freedom, modernity and fashion. In high-income settings, female smoking can also be linked to the belief that it reduces appetite and helps to control body weight to achieve the most desirable (slim) body image.

Research has been focusing on how the tobacco industry and its [aggressive marketing strategies](#) have manipulated gender norms to expand markets and target youth and women. Traditional norms that link smoking to manhood are used when young men are targeted, while smoking is marketed to female customers as a way for them to challenge the gender norms that constrain their lives. When the industry first targeted women in HICs in the 1920s, cigarettes were sold as ‘torches of freedom’, with female smokers portrayed as representing the modern woman.

In today’s LMICs, the tobacco industry is tapping into women’s increased autonomy, the expanding middle class and large young populations as a way into new markets. Women and girls in sub-Saharan Africa, for example, are deliberately targeted by tobacco marketing through the use of trend-setters who promote and normalise the image of the African woman smoker in an effort to tackle barriers and make female smoking more socially acceptable.

Studies have also pointed out that [adolescent girls and boys are vulnerable to tobacco marketing](#) through traditional media, such as smoking imagery in films, television and magazines. At the same time, health campaigns to tackle tobacco use may reproduce gender stereotypes about the emphasis women and girls place on beauty and physical appearance by highlighting how smoking ages the skin.

2.4 Alcohol use

Harmful use of alcohol is a major risk factor not only for NCDs, but also for many injuries, including those caused by road accidents and interpersonal violence, including intimate partner violence. It is also a risk factor for infectious diseases, including HIV and STIs.

In 2016, [harmful alcohol use](#) accounted for over 5% of all deaths worldwide. While there are regional and country variations, harmful drinking patterns are more prevalent in Europe and the Americas. Although alcohol-use disorders were more prevalent in HICs in 2016, the disease burden attributable to alcohol was highest in low-income countries (LICs) and lower-middle income countries. Mortality and disability linked to alcohol and substance abuse are higher for men than for women. It also appears that cultural and religious factors and social norms affect drinking patterns, as well as the physiological differences between men and women.

The use of alcohol usually starts in adolescence. Globally, about [one in four 13-15-year-olds](#) report having used alcohol during the last 12 months, with alcohol cited as the substance used most commonly by school students worldwide. [More than a quarter of all older adolescents](#) aged 15-19 are current drinkers, with the highest prevalence of alcohol abuse found among boys in Europe, the Americas and the Western Pacific regions. The 2013 Global Burden of Disease study found that alcohol use was the [leading global health-risk factor](#) associated with mortality among adolescent boys aged 15 to 19 years. Street children and adolescents are particularly vulnerable to alcohol and substance use.

Norms about masculine and feminine behaviours

[Social attitudes](#) towards the acceptability of drinking and drunkenness are clearly influenced by masculine and feminine ideals. Drinking is typically seen as a demonstration of masculinity and, therefore, more normal or permissible for boys and men. It is particularly linked to male willingness to take risks or the male perception that alcohol enhances sexual performance. It is also promoted as a social bonding activity, especially among boys and young men. Alcohol

consumption is also seen as a way to avoid responsibilities or deal with feelings of powerlessness and vulnerability.

Difficulties in achieving the masculine ideals prescribed by prevalent norms, especially in relation to the male breadwinner role, may prompt young men to drink heavily in settings characterised by economic hardship and limited opportunities. The [sharp drop in male life expectancy recorded in Russia](#) in the 1990s, for example, was linked partly to increased risky behaviours such as heavy alcohol consumption due to high unemployment, stress and weak support networks at a time of economic and political upheaval.

The [IMAGES survey](#) has found that younger men, men with lower education levels, those with work stress and men with inequitable attitudes to gender are more likely to report regular alcohol abuse. In the case of adolescents, attitudes towards traditional gender ideals have also been found to [mediate the relationship between gender and drinking](#). Here, the effects are stronger among adolescent boys, as they are particularly exposed to messages from multiple sources that link drinking to manhood.

A considerable body of literature, largely from HICs, highlights the role of [peer](#) and [parental influence](#) on drinking for adolescent boys and girls. Boys tend to be monitored less by their parents than girls, giving them more opportunities to engage in harmful alcohol consumption. In contrast, girls may be more likely to put pressure on their female friends not to drink.

Evidence from various settings shows that [drinking is often less acceptable for women](#), especially in public spaces, as it is traditionally seen as unfeminine, immoral or immodest. Young women who get drunk may be perceived as sexually available or promiscuous. However, women in many regions have been responsible for the production and distribution of alcoholic beverages at local level. Recent changes in female education, employment and economic independence, coupled with a shift in traditional norms and gender roles, have contributed to increased alcohol consumption among women and increasing convergence in male and female drinking patterns.

Research findings from LMICs suggest that there are [considerable differences between groups of female drinkers](#). Less educated and low-income women in rural and urban settings may resort to heavy consumption of easily available, poor-quality alcoholic drinks for temporary relief. Young female drinkers in urban areas with higher education and some economic independence who see drinking as acceptable may drink to facilitate socialisation, enhance positive experiences or ease tension. Even so, persistent norms about alcohol consumption mean that women who have alcohol-related problems find it more difficult than men to access health care and face more criticism and rejection from partners and society.

There is [evidence](#) that as is the case with the tobacco industry, alcohol manufacturers are explicitly targeting urban youth and women in LMICs. Using aggressive marketing techniques that build on shifting gender norms, they aim to attract new consumers.

2.5 Air pollution

Exposure to air pollution, whether outside or in the home, has adverse and life-long health effects, including respiratory infections, heart disease, stroke and cancer, with the heaviest disease burden recorded in LMICs. WHO estimates that ambient (outdoor) [air pollution caused 4.2 million premature deaths in 2016](#), with 91% of these deaths occurring in South-East Asia and

the Western Pacific. In addition, [nearly 4 million people die prematurely each year](#) from illnesses attributed to household air pollution, largely because they lack access to clean cooking fuels and technologies.

Norms about gender roles and exposure to risk

In many LMICs, [women and girls are the main providers and users of household energy services](#) as they are responsible for domestic tasks such as preparing meals, tending fires and keeping the home warm, while having to spend more time in and around the home than men. They often use polluting fuels and technologies such as wood, dung and charcoal, open stoves, kerosene lamps and other polluting devices to meet basic household needs on a daily basis.

Their higher exposure to such polluting fuels and technologies heightens their risk of associated diseases, and women and children [accounted for 60% of all premature deaths](#) attributed to household air pollution in 2012. This makes household air pollution the second most important health-risk factor for women and girls worldwide. This particular health risk correlates strongly with poverty, as it is [low-income and rural households](#) that depend on such fuel sources.

Data from Pakistan show that more than 99% of women and girls from the poorest rural households lack access to clean fuel, compared to only 1% of those from the wealthiest urban households. Similarly, in Colombia, 76% of indigenous women and girls in the poorest rural households lack access to clean cooking fuels.

3. Communicable and infectious diseases and gender norms

Tuberculosis (TB), malaria and the so-called neglected tropical diseases, including schistosomiasis, trachoma and lymphatic filariasis, continue to affect millions of women and men in LMICs. Communicable or infectious diseases are associated strongly with poverty, adding to the threats to the wellbeing of people who already face hardship and poor living conditions.

Norms about gender roles and exposure to infection

Gender norms that shape the division of labour within the household, as well as work and leisure patterns and sleeping arrangements, influence [exposure to infection](#) for both women and men. Boys and young men working in forestry, fields or mines at peak mosquito biting time are more exposed to malaria infection than women who are in the kitchen, protected from insect bites by the smoke from cooking fires. Men may also have an increased risk of exposure in settings where they sit outside at dusk or sleep outdoors. Women and girls who perform household chores before dawn may also be exposed to mosquitoes and the malaria parasite, while those living in conservative communities where they have to cover their bodies for modesty have a lower risk of exposure.

Girls' and women's responsibility for collecting water and washing clothes in rivers in several LMICs exposes them to [water-borne and water-related infectious and neglected tropical diseases](#) including schistosomiasis. Yet boys who play in infected rivers and canals often have a higher prevalence and intensity of schistosomiasis infection. Where the mobility of girls and

women is restricted, as in conservative Muslim countries, they are less exposed to water and, therefore, have lower rates of the infection.

Care responsibilities leave women and girls more vulnerable to [trachoma infection](#), with women being more exposed than men to persistent infection and having a risk of trachoma-related blindness that is two to four times higher than the risk for men. Young children pass the infectious agent to their mothers, while crowded living conditions, poor hygiene and smoke from cooking fires make eyes susceptible to infection.

Norms about feminine and masculine behaviours

Because women tend to be more risk-averse, and because they have to take care of children, they are more likely to use insecticide-treated nets (ITNs) than men. While most of the literature on malaria focuses on pregnant women because of their increased vulnerability, one [study in Nigeria](#) found that adolescent boys and young men aged 15-25 were the group least likely to use an ITN.

Men's increased risk-taking, including alcohol and tobacco use, increases their exposure to TB infection. They may also wish to conform to the masculine ideal of showing strength in the face of adversity, and delay seeking care for infection. In urban Malawi, many low-income young men heading households have tried hard to display the stoicism expected of them in public and have [delayed seeking care for TB](#) or used alcohol to manage their pain in private.

Norms about gender roles and access to healthcare

Women with household responsibilities – particularly those with young children – may prioritise these and delay seeking treatment for their own severe infections. Men, however, may delay because they are more concerned about the loss of household income. The need to provide for the family and live up to the expectations associated with being the head of household may prompt men to delay seeking care.

In a context of high unemployment and low incomes, [men in urban Malawi](#) delayed treatment for TB to continue bringing money home and avoid being seen as 'less than men'. Similarly, a [study in Kenya](#) on how gender undermined follow-up appointments in a large HIV treatment programme found that work commitments were the principal reason reported by men, while women reported that family commitments were the main reason for missing scheduled visits to the clinic.

Norms about decision-making over use of household resources and access to healthcare

The health problems of adolescent girls and young women may be seen as a lower priority than male health in various settings with scarce resources. This is also linked to their limited economic autonomy and the devaluing of their contribution to household income. [Two reviews](#) on the factors that affect the uptake of malaria interventions during pregnancy in sub-Saharan Africa have pointed out that pregnant women depend on their husbands to access malaria treatment because they often control household resources, including paying for transportation to the health facility. In some cases, husbands must give their consent for their wife's attendance at a clinic or for her medication.

Although [women are more likely to use ITNs than men](#), they may also be [less able to access them](#) as they have limited decision-making power or may lack the financial capacity to buy or re-treat nets, leaving them dependent on men for this. It has also been suggested that a male

head of household who is the primary breadwinner and controls resources may be given priority use of an ITN if there are not enough nets for every household member.

Norms about stigma

Studies have identified stigma and women's greater vulnerability to discrimination as shaping their access to health care for infectious diseases. Many adolescent girls in sub-Saharan Africa find it hard to access reproductive health services, but pregnant adolescent girls (who are particularly vulnerable to malaria infection and its effects) may face even greater [difficulties in accessing ante-natal care and malaria treatment](#) because of the shame associated with adolescent pregnancy and the negative attitudes of family, community and health providers.

While data indicate that men have higher TB prevalence and mortality rates than women, some studies have questioned this finding, given the under-reporting and under-treatment of women with TB – the result of stigma and fear of social discrimination, as well as of their more limited access to health care. From [Latin America](#) to [South and East Asia](#), in settings where TB is highly stigmatising, women with TB face rejection, divorce and abandonment or are unable to find a husband after their diagnosis.

As a result, women report delaying treatment, hiding their diagnosis and relying on self-medication or traditional healers and informal health providers to ensure anonymity and privacy. Fear of family rejection and social isolation, coupled with women's higher sensitivity to stigma surrounding TB, can lead to under-reporting of female TB cases.

4. Nutritional status and gender norms

An often-cited estimate suggests that women and girls account for around 60% of the world's chronically hungry people. [Data from more than 140 countries](#) in Africa, Asia and Latin America show that women have a higher prevalence of severe food insecurity. [Higher levels of gender inequality](#) are also associated with higher levels of both acute and chronic undernutrition.

There is an emphasis on adolescent girls in the literature, given high rates of early marriage in some regions and the association of thinness with adverse pregnancy outcomes for both mother and child. South Asia, for example, has the highest [prevalence of thinness among adolescents](#). National survey data indicate that 47% of Indian adolescent girls aged 15–19 are underweight, with a body mass index (BMI) of less than 18.5. In addition, data from 21 LMICs show that more than one third of girls of this age group are anaemic. The intersection of gender with wealth, location and ethnicity increases nutritional disadvantage: in [Pakistan](#) 40.6% of the poorest rural women aged 18–49 from the Sindhi ethnic group are undernourished (with a BMI below 18.5) compared to a national average of 13.3% and an average of 2.4% among women of that age group from the richest urban households of the Punjabi majority.

At the same time, obesity is a growing global concern. Undernutrition, obesity and micronutrient deficiencies co-exist in many LMICs, with poor access to healthy food contributing to malnutrition. [Data from 10 LMICs](#) show that between 20% and 37% of girls aged 15–19 are overweight. There is also a growing focus on adolescent nutrition because the development of healthy eating habits at this time is a foundation for good health and a safeguard against obesity and related NCDs in adulthood.

While medical and public health literature pays little attention to the role of gender norms on the nutritional outcomes of adolescent girls and young women, some research on nutrition and food security includes relevant information especially in settings still characterised by undernutrition. Meanwhile, behavioural sciences are exploring the role of norms and peer pressure on adolescent obesity and overweight.

Norms about access to food

The role of gender norms in shaping food allocation within households has emerged as a key focus of research on nutrition and food security. Studies on South Asia, for example, indicate a clear [pro-male bias in food allocation](#) and nutritional outcomes that starts early in life. Indian girls, especially second-born girls, are [breastfed for shorter periods and have lower consumption of fresh milk](#) than boys, while their nutrition is also affected by caring practices that privilege boys.

Such discrimination continues into adolescence and youth, despite variations between and within countries and some evidence of gradual change in certain contexts. In areas with a strong son preference, this bias in favour of boys persists among wealthy households because of the higher costs associated with dowries for girls.

Although women play key roles in food production, selection and preparation, men make the decisions about food allocation in contexts with persistent gender inequality. This is linked to their greater social status and access to power and resources, as well as the perception that they contribute most to the household income and should, therefore, decide who eats when and what. More food is also allocated to those carrying out heavy physical work in which performance depends on nutritional input. Some evidence has suggested that the dowry a wife brings into a household can [increase her status](#), including access to better food.

In [some South Asian communities](#), the tradition that the male head of the household is served first and that women are served after men can undermine women's nutritional status, with female household members eating last, eating only what is left over and not having enough food. In some cases, the daughter-in-law is the last to be served. Where food is not served in equal portions and men and boys eat until they are satisfied, women and adolescent girls may be left with nothing to eat, even during pregnancy and lactation. Food quality is also an issue, as men may also have preferential access to special foods of higher prestige. These gender biases are exacerbated when resources are scarce, such as the lean season or during crises and natural disasters.

Gender discrimination in food allocation is also reported in other regions. In [Ethiopia](#), for example, adolescent girls aged 13–17 in households affected by food insecurity are more likely than boys to report being food insecure (a proxy indicator for insufficient food). The largest gender gaps are reported in households that are severely food insecure, where close to 40% of girls have reported food insecurity while their brothers have not. In addition, adolescent boys and young men have greater freedom of movement and can spend more time away from home and find food elsewhere. They may also receive small amounts of money from their parents to buy snacks, which is rarely the case for girls.

Norms about food preferences and restrictions

Many cultures associate [certain foods and eating habits](#) with masculinity and others with femininity. Meat (particularly red meat) is seen as the archetypical [masculine food](#), while dieting, eating lightly or eating healthier foods are often linked to feminine eating behaviours.

Adolescent girls and young women may also face food restrictions at certain phases of their life linked to their reproductive roles. In several settings they are expected to avoid consuming certain foods during menstruation, pregnancy or lactation, even though denying them some nutritious food (and even water) can lead to undernutrition or micronutrient deficiencies. In some [parts of rural Nepal](#), for example, menstruating women and girls are seen as impure and untouchable, are forbidden to touch food or enter the kitchen, and are even confined to animal sheds with little to eat. Similarly, Hindu mothers are confined after childbirth and must avoid sour, spicy and oily food, as well as almost all fruits and many vegetables.

Norms, body image and eating behaviours

Studies on [nutrition, gender norms and adolescent girls](#), often from high-income settings, tend to focus on their dieting habits or unhealthy weight-control behaviours, rather than on healthy nutrition. Evidence shows that adolescent girls may be more concerned than their male peers about their body image and how others see them. Their eating behaviours are, therefore, associated more with the achievement of a feminine bodily ideal – particularly a body size and shape that is acceptable and desirable – than with their health.

Many studies emphasise that [adolescent girls face considerable societal pressures](#), tend to be preoccupied with their weight and report greater body dissatisfaction than boys. This belief intensifies as they move from early to older adolescence. For example, in every country and region covered by the 2013/14 [HBSC survey](#), girls reported being too fat: 43% of 15-year-old girls admitted being dissatisfied with their body appearance – nearly double the rate for boys – and 26% reported being on a diet although only 13% were overweight. A large proportion are trying to lose weight and risk developing eating disorders as dietary habits and perceptions about ‘ideal’ bodies change. Body image issues and eating disorders are also having an increasing impact on adolescent boys, who face their own pressures from family, peers and the mass media to look a certain way.

Peer pressure, exposure to media and context all shape feminine and masculine body ideals and eating habits. In several cases, the distorted body image perceived by the individual does not reflect their actual body weight and can lead to unhealthy diets and disorders. Exposure to media has a particularly strong association with problems around body image. A study of [young university students in Pakistan](#) found that those who had a high exposure to media had higher (and statistically significant) rates of dissatisfaction with their bodies than students with lower media exposure.

Another study of [high school students in urban Thailand](#) pointed out that the use of the Internet and social networks in relation to body image and eating behaviours had a positive correlation with the risks of eating disorders, bingeing, purging, and the use of laxatives and weight-loss drugs. A review of evidence on the [links between body image, eating disorders and Internet use](#) has noted frequent cyberbullying related to appearance among adolescents using social media platforms, with the greatest prevalence among girls, resulting in low self- and body-esteem.

5. Physical integrity and gender norms

Physical integrity includes issues of violence, body modification and unintentional injuries that affect adolescents and youth, in particular, in LMICs. The role of harmful and restrictive gender norms in increasing vulnerability to these issues has been identified consistently in policy, research and programming. The [Global Accelerated Action for the Health of Adolescents \(AA-HA!\)](#), for example, refers explicitly to gender and social norms that need to change to prevent and respond to all forms of violence against adolescents, or to prevent and mitigate road traffic injuries. Similarly, more studies and interventions are analysing different types of norms that are implicated in the perpetration of gender-based violence (GBV).

5.1 Violence

Defined by [WHO](#) as the intentional use of physical force or power against another person with a high likelihood of injury, death, psychological harm, mal-development or deprivation, violence in all its forms affects the lives of millions of young women and men worldwide, with long-lasting health and social consequences. While boys and men are affected by violence, girls and women account for the vast majority of survivors and victims.

Given its extent, violence against women has received the most attention, with intimate partner violence being the form of violence surveyed most extensively, followed by sexual and youth violence. Experts agree that violence has strong links to [social and gender norms](#) and [unequal gender relations](#): violence against women and homophobic violence, for example, are clear manifestations of power. They are rooted in hierarchical and unequal social relationships that subordinate women (and those men who do not conform to dominant gender norms) to men and are used to maintain gender inequality while reaffirming men's privileged status. There is, therefore, agreement that strategies to tackle violence should promote gender quality and explicitly include [efforts to change harmful norms](#) that support the use of violence.

Intimate partner violence

Global estimates indicate that nearly [one in three women aged 15 and over](#) has experienced physical and/or sexual violence by a male intimate partner at some point in her lifetime. Nearly 37% of women in Africa, the Eastern Mediterranean and South-East Asia report having experienced intimate partner violence (IPV) with prevalence rates higher in LMICs. The two [global studies](#) on men and violence reported IPV perpetration rates ranging from 25% to 40% or even 80% in some cases.

Such violence starts early: an estimated 29.4% of girls aged 15-19 and 31.6% of women aged 20-24 years have experienced [physical and/or sexual IPV](#). [Some evidence](#) actually [suggests](#) that the younger the woman, the higher the risk of IPV, with girls who marry early at particular risk. The context matters, with studies identifying particular gender norms that contribute to IPV, while lower prevalence is also associated with having a [higher proportion of women in the formal work force](#).

Norms about male authority and the subordination of women

In many contexts, girls and women are seen as the property of men: to be controlled and submit to male power without challenging it. The [IMAGES survey](#) found that men who adhere to rigid norms of masculinity (agreeing that 'men need sex more than women', or that 'men should dominate women') are more likely to report use of violence against a female partner. Likewise,

a study of [survey data from 44 countries](#) found that living in countries or regions where there is widespread acceptance of male authority over female behaviour has significant associations with IPV.

Qualitative [research in South Asia](#) has also confirmed that both men and women accept and justify such violence as necessary to teach women obedience, control them or force them to adhere to acceptable gender behaviours. Analysis of data from [global population-based household surveys](#) has found that men with multiple sexual relationships are also more likely to resort to IPV.

Norms that justify male violence against women

Three [studies](#) that [analysed](#) population survey [data](#) concluded that attitudes supporting wife beating increase the risk of IPV. Not only is [male agreement](#) with wife beating a strong predictor of IPV, but women who [support wife beating](#) are at greater risk of IPV themselves.

Research stresses that there are many settings where the use of violence to settle tensions or resolve disputes is seen as acceptable and normalised. However, men are more likely to condone and perpetrate violence against women if they [witnessed](#) inter-parental violence and [experienced violence](#) themselves in childhood, while women who have witnessed their fathers beating their mothers are far more likely to [experience IPV](#) in most settings.

Norms about the use of violence to punish 'transgression'

Although what constitutes acceptable behaviour for women and men varies by context, studies note that the use of violence is seen as particularly [justifiable when women and men transgress gender norms](#) that regulate their sexual behaviour. For example, 'bad girls' 'easy girls' or 'sluts' are at greater risk of violence and may be seen as 'deserving' it for defying norms of female respectability. This could include engaging in 'immoral' actions such as premarital sex in contexts where sex is associated solely with marriage or exposing parts of their body to the male gaze. Such norms can also include norms about family honour, with male family members responsible for monitoring female behaviour and intervening with violence when young women act in ways that could damage the family's reputation.

Norms about male toughness and aggression

Evidence from the [IMAGES study](#) suggests that men who carry firearms, and who are involved in other violent acts or criminal behaviour, are more likely to report having used IPV. Similarly, [analysis of population survey data](#) has also found that men who often resort to violence and fight other men are more likely to abuse their partners than those who avoid fighting in general. Here, men adhere to masculinity ideals linked to aggression and the use of violence to demonstrate and reaffirm their manhood.

Norms about gender roles

Men who are cannot live up to the [traditional gender role of the provider and protector](#) of the family and who feel that their identity is at stake may resort to violence to reaffirm their damaged masculinity and retain their control over the women in their household. The [IMAGES survey](#) found that men in some contexts who experienced work-related stress were more likely to report using violence against their intimate partners. In most countries covered by the survey, there was a clear association between men reporting economic stress and higher rates of IPV.

Sexual violence

Sexual violence includes violence perpetrated by either an intimate partner or a non-partner, although it appears that sexual violence by an intimate partner is more [common](#). Global estimates indicate that [18% of girls and 8% of boys have experienced sexual abuse](#). Worldwide, [over 7% of women](#) report having experienced sexual violence by a non-intimate partner.

In the [UN multi-country study](#) on men and violence in Asia and the Pacific, between 10% and 62% of all men interviewed reported perpetrating some form of rape against a girl or a woman in their lifetime, with half of men reporting doing so for the first time when they were adolescents. Between 2% and 8% of men also reported having perpetrated rape against another man. Most men who raped another man had also raped a female non-partner, and the greatest overlap in reporting was seen in male rape and the gang rape of women.

Sexual violence intensifies during conflict. A [systematic review](#) has estimated that nearly one in five refugee or displaced women in humanitarian settings reported some form of sexual violence. Given the sensitivity of such information and how difficult it is to disclose, this is very likely to be an underestimate of the true extent of the problem. As well as sexual violence by armed combatants, women and girls are also at [high risk of sexual violence](#) at the hands of their intimate partners and other civilians.

Boys and young men are also vulnerable to sexual violence during conflict. For example, [sexual violence against men](#) was reported in 25 countries affected by conflict between 1998 and 2008. A [UNHCR study](#) found that Syrian refugee adolescent boys and men are vulnerable to sexual abuse both in Syria and in host countries.

Norms about heterosexual performance and sexual dominance

Studies find that sexual violence is often associated with the performance of [aggressive masculinity](#): an extreme demonstration of heterosexual masculinity and sexual dominance over women or men who do not conform to prevalent norms about sexuality. Sexual violence can, therefore, be used as a tool to regulate the gender performance of women and men.

The [UN study on men and violence](#) argued that the perpetration of rape has strong associations with having multiple sexual partners, engaging in transactional sex, and participating in violence and fighting between men with weapons. Similarly, findings from the [IMAGES study](#) show that men who engaged in transactional sex, who had multiple sexual partners and who held inequitable attitudes towards gender were more likely to perpetrate rape. Having a score below average on the [Gender-Equitable Men \(GEM\) scale](#), which measures attitudes towards gender norms, increased the likelihood of men's reported sexual violence by as much as 3.5 times.

The [IMAGES study](#) also emphasised that men who were exposed to violent experiences in their childhood – whether having experienced physical or sexual violence or parental neglect or having witnessed violence against their mothers – tend to perpetrate sexual violence at higher rates than those who were not.

Considerable attention has also been paid to male peer groups such as gangs, which tend to be characterised by norms around the need to demonstrate heterosexual prowess. For example, [evidence from Southern Africa](#) shows that gang culture is characterised by dominant notions of masculinity, with new members having to undergo initiation rituals that can involve violence

and the rape of women and girls. Members who fail to display such prowess can be [ridiculed](#), insulted or attacked.

Norms about the male 'right' to sex and the use of female bodies

In many settings, 'real men' are seen as those who appear unable to control their sex drive – a drive that they are also entitled to satisfy as they wish. Such norms coexist with norms that devalue and objectify women. [Norms about male sexual entitlement](#) exclude both the possibility of a woman rejecting a sexual advance and any notion that she has the right to make her own decisions about sexual intercourse and consent. A considerable body of evidence focuses on the role of media that objectify women's bodies and tolerate violence against them.

Norms about masculine behaviours and access to support services

Studies have also noted that dominant norms and expectations of masculinity have [negative consequences for boys and men](#) who experience sexual violence and abuse. Male survivors face great difficulties in accessing health care and support services, not only because they need to show strength but also because of the stigma linked to homophobia. In Kenya, only 46% of women and 36% of men who experienced sexual violence in childhood revealed the incident. In some cases, male vulnerability to sexual violence is seen as inconceivable and boys and men may have even less legal protection than girls and women, resulting in more limited access to relevant services.

Youth violence

Over 80% of deaths caused by youth violence occur among men. In particular, adolescent boys and young men aged 15-29 have the highest [homicide rate](#) of any age group – 18.2 per 100,000 compared to average rates of 10.8 for males and 3.2 for their female peers, with young women largely victims of IPV. Most youth homicide deaths occur in LMICs, and particularly in Latin America where youth violence is linked to the use of firearms in violent encounters and participation in street gangs, followed by West and Central Africa.

Norms around male toughness, aggression and dominance

Boys in many settings are taught that they must be strong, tough and aggressive. Indeed, data confirm that [boys are more vulnerable to physical abuse than girls](#) in childhood.

The use of violence as a legitimate way to resolve tensions can be promoted by the belief that parents and teachers should use physical violence to control children, with boys being more likely to be physically punished. Boys often learn that physical violence is normal and that violence against peers demonstrates masculinity and is a valid way to earn peer respect, with nearly one in two males across all countries reporting [involvement in physical fighting](#) compared to one in four females.

Military training also creates an environment that accepts violence, while [studies from Latin America](#) show that gangs confer higher status on members who are physically stronger and who conform to dominant and violent norms of masculinity.

In contrast, boys who display traits that challenge acceptable standards of gender presentation and sexual orientation are often bullied by their peers, facing greater sanctions than girls who often enjoy greater flexibility. A study with younger adolescents aged 11-13 years in urban poor sites in four countries found that [boys who challenged local gender stereotypes](#), because their

appearance or behaviour were perceived feminine, faced insults and name-calling such as 'gay', 'sissy' or 'weirdo'.

Analysis of a large [national sample of American youth](#) aged 14-22 found that gay males and lesbians were more likely to report having been bullied than their heterosexual peers. Another study found that adolescent [boys who do not demonstrate standard masculinity traits](#) in terms of being muscular, tall, heterosexual and dominant are more likely to be targeted by their peers in school. Those who were short, overweight, had a disability, belonged to an ethnic minority, had a different religion or were perceived to be poor were also thought to be weak and became easy targets for other boys who wanted to demonstrate dominance and prove their manhood.

Norms around male risk-taking behaviours

In some settings, the possession of weapons (including firearms), is a symbol of masculinity and their use is normalised and tolerated as a way for men to settle their disputes. The [IMAGES study](#) found that gender attitudes are linked to criminal activity: men who adhere to more inequitable gender norms are more likely to have a firearm and to have engaged in fighting with a weapon. However, the most significant risk factor for men's participation in criminal activity is their socioeconomic status.

5.2 Body modification

Gender norms also influence body modification practices that change the appearance and shape of the body to make an individual more 'acceptable' or 'attractive'. These range from tattooing and skin lightening to muscle-toning and cosmetic surgery. Some practices are seen as voluntary, individual choices, while others are seen as a prerequisite for membership in a group and are imposed on the individual.

Female genital mutilation/cutting (FGM/C), for example, is a traditional practice embedded in broader cultural systems that is seen as essential for personhood and identity, even though it harms the health and wellbeing of girls. In contrast, [tattoos and body piercings](#) are popular among adolescents and youth, especially in HICs. This ancient art has been linked to rites of passage in various cultures worldwide, and has been linked to particular groups, as well as masculine and high-risk identities such as sailors, prisoners or members of motorcycle gangs. Since the 1990s tattooing and piercing have become part of popular consumer culture.

While public health experts focus on hygiene and health risks, sociological analyses argue that tattooing can be seen as a sign of control over one's body and as an expression of one's identity and beliefs. [Evidence](#) from Western contexts suggested that adolescents, in particular, use tattoos to assert their autonomy and challenge standard norms of appearance or demonstrate group membership.

Existing research, mostly in HICs, indicates that adolescents and youth are often concerned about their appearance and are vulnerable to social pressures about how they should look. It has identified the critical role of social norms that prompt youth to follow specific practices, and of gender inequality and related norms that force women in particular, but also men, to undergo sometimes harmful practices that have serious consequences for their health and wellbeing.

Girls appear to be more vulnerable than boys to pressures from family, friends and mass media, tend to express greater dissatisfaction with their developing bodies and increased body fat,

and are more likely to change them to bolster their self-esteem and gain social acceptance. Studies find that young adolescent boys and girls often [equate femininity with beauty and attractiveness](#), and that the physical appearance of girls is assessed constantly against established standards, with their peers playing an active role in the enforcement of such norms.

Norms about feminine bodies and behaviours

Adolescent girls and young women undergo various types of body modification practices, including tattooing, skin lightening, strict diets or surgical procedures. While they may sometimes be aiming to challenge established norms, in most cases the goal is to re-shape their bodies so that they align with the dominant gender expectations of how they should look.

While [tattoos](#) indicated membership of male sub-cultures in Western contexts in the past, some women, including upper-class women, also acquired tattoos. This challenged normative ideals about feminine beauty and was often socially rejected, with tattooed women seen as sexually promiscuous or of lower social status. Today, however, tattoos are normalised as part of youth popular culture worldwide. Women's tattoos have various [motivations](#) and [communicate](#) a range of personal and cultural messages from embellishing the body to reclaiming its control, and – depending on the designs – from conforming to gender stereotypes to challenging them.

Where darker skin is believed to be less attractive, women and girls may resort to using skin lightening creams and cosmetics. In [sub-Saharan Africa](#), the [Middle East](#) and [Asia](#), lighter skin tones are associated with beauty, higher self-esteem and social status and better opportunities for marriage and employment. However, many of these substances are toxic and result in serious health problems.

As well as following restrictive dietary regimes that can lead to eating disorders, young women increasingly go under the knife, having various types of cosmetic surgery to change body parts that they believe are inadequate, and that fail to conform to dominant ideals of feminine beauty. Breast enhancement, rhinoplasty, liposuction and genital surgery rates are on the rise, as is the number of adolescent girls modifying their bodies, as seen in [Brazil](#).

Studies note that body modification is sometimes presented as a form of agency and individual determination that can improve perceptions of the self. Yet Western [feminist scholarship's critique](#) of cosmetic surgery has stressed that patriarchy has always reduced women to their looks. They have been conceptualised as objects of the male gaze, constraining their agency and autonomy, and have been manipulated to conform to patriarchal beauty ideals. Globalisation, consumer culture and mass media have made cosmetic surgery popular among women – and increasingly among men – in both high and low-income settings in recent years.

Norms about female modesty, family honour and subordination of women are embedded in traditional body modification practices and entrenched in broader cultural systems. They are maintained because communities see them as essential for group identity and beneficial for girls, regardless of their harmful consequences for health and wellbeing. For example, [breast-ironing](#) is practised in West Africa and refers to pounding or massaging the developing breasts of girls with hot objects to suppress their growth and flatten them so that they do not attract male attention.

[Foot binding](#) was an ancient tradition practised on young girls in China for nearly a thousand years because a small foot was seen as vital for girls' marriageability and was associated with restricted mobility, sexual control and the subordination of women. Its abandonment in just one generation was achieved through education campaigns to show that the practice was not universal and to highlight the advantages of natural feet, and through the creation of societies whose members pledged to leave their daughters' feet unbound and refuse to let their sons marry girls with bound feet.

FGM/C is another traditional practice performed on female genitals for non-medical reasons with very harmful effects. While accurate data are unavailable, it is estimated that [at least 200 million girls and women have been cut in 30 countries](#), and that the practice continues in some migrant communities in Europe and North America. There are variations in the form of FGM/C used and the age at which girls are cut, with differences observed even within the same country.

FGM/C is widely perceived as a form of [violence against women and girls](#) and a violation of their rights. Yet its supporters argue that it is important for a woman's status, chastity and family honour, marriageability, beauty or even health. Research finds that its continuation may also be linked to ethnic identity, perceived religious obligation or adolescent rites of passage.

The causal factors vary by context: research in West Africa has found that FGM/C is not linked directly to marriageability but is [upheld by a peer convention](#) signalling to other women that a girl can be included in their social network, with the practice seen as central to personhood, social cohesion and cultural identity. One common thread is that the practice has a collective character and involves [social rewards](#) as well as punishments for those who do not conform to group requirements.

It is no coincidence that FGM/C is often referred to as a social norm and its abandonment has been linked to the adoption of a social-norms perspective. As the practice is embedded in context-specific systems of values and beliefs, current efforts for its elimination focus on [work with communities](#), including boys and men as well as traditional and faith leaders, to change attitudes and behaviours, alongside legislative change and targeted campaigns to raise awareness.

Norms about masculine bodies and behaviours

Although most research has focused on women, body modification issues are increasingly affecting men, who are no longer immune to pressures around their appearance. Young men are vulnerable to gender norms about masculine ideals linked to the body, and are increasingly undergoing cosmetic surgery, and using skin lightening and other beauty products or adopt exercise and dietary regimes to deal with body dissatisfaction. One study with a representative sample in [Mexico, UK and the US](#) found that nearly half of the young men surveyed admitted to being dissatisfied with the size of their muscles and said that their weight or body shape were the aspects of their physical appearance they would most like to change.

A lean, muscular body is often promoted by popular culture and mass media as the ideal body shape for men. Where masculinity is linked to muscularity, adolescent boys and young men exposed to normative male ideals may engage in [muscle-enhancing techniques](#), such as excessive exercise, or use muscle-enhancing substances such as anabolic steroids and other

supplements to achieve the desired appearance. Such substances can expose youth to serious health risks.

A study on the [use of internet and social media](#) by secondary-school students in Bangkok, Thailand, to find content on body image found that girls purchased more beauty products, while more boys bought sporting equipment and muscle-strengthening or weight-gain products. Their media usage had a negative association with body satisfaction and a positive association with the drive for muscularity among boys. Similarly, a significant percentage of young Lebanese men exposed to overly muscular male models in media, including pornography, were more likely to believe that women prefer muscular men, and [used dietary supplements or steroids](#) to enhance their body image.

5.3 Unintentional injuries

Hundreds of thousands of adolescent and youth die from unintentional injuries every year, while those who survive often face serious health and social consequences. [Unintentional injuries](#) are a leading cause of death and disability for adolescents, especially those living in LMICs and in poor settings. There are five main types: road traffic injuries, drowning, burns, falls and poisonings. With the exception of burns, boys and young men are more vulnerable to unintentional injuries and suffer more frequent and more severe injuries than girls and young women.

Adolescent boys and young men are [at high risk](#) of suffering injuries from road traffic accidents in LMICs, especially where road safety is poorly developed. They are also twice as likely to drown as females. Nearly 60% of drowning deaths occur among under the age of 30 years, with drowning the third leading cause of death worldwide for children and early adolescents aged 5-14 years. Once again, over 90% of drowning deaths occur in LMICs.

Adolescents and youth in hazardous occupations are particularly vulnerable to falls, while older adolescents have a high prevalence of poisoning that may be linked to substance use such as unintentional drug overdoses or to participation in risks related to their work. In contrast, young women [have higher rates](#) of death from burns than men: in some cases they exceed those of men by up to 50%. The vast majority of burns occur in LMICs with almost two-thirds in Africa and South Asia. Gender norms about masculine and feminine behaviours and gender roles tend to shape adolescent and youth vulnerability to unintentional injuries.

Norms about masculine behaviours

Taking risks is typically seen as a masculine trait in many settings. Adolescent boys and young men, therefore, may engage in [behaviours that increase their risk of traffic injury](#) such as consuming large amounts of alcohol, driving at high speeds and engaging in illegal racing, especially as members of male groups, to demonstrate their masculinity. Research in [Mexico, the UK and the US](#) has demonstrated that young men conforming to traditional masculine norms are two to three times more likely to report having been in recent traffic accidents. Peer pressure can also have a negative effect, with some research signalling that young drivers experience higher peer pressure than older drivers to [commit traffic violations](#) such as speeding, not using seat belts, or drinking and driving. Consuming alcohol and then trying to swim also increases the risk of drowning.

Norms about mobility and exposure to risk

Different rates of injuries between male and female youth in some settings are linked to norms about mobility. While norms may restrict female mobility, young men are encouraged to be more active, and spend more time outdoors as pedestrians, passengers, bicyclists, motorcyclists or car drivers. As a result, they are more likely to [experience traffic injuries](#).

Norms about gender roles and exposure to risk

Because older adolescent boys and young men in many settings are more engaged in income-generating activities and hazardous employment, they are more vulnerable to traffic accidents, drowning, falls and occupational injuries. Girls and young women, however, tend to spend a considerable amount of time in the kitchen, where they are [more exposed to fire and hot substances](#).

In low-income settings, female burns are often caused by the use of open-fire cooking or unsafe cook stoves and by flames that ignite loose female clothing. However, growing evidence from South Asia links higher incidence of burns among young women to self-directed or interpersonal violence. In [India, for example](#), burn-related injuries and deaths among young women could be caused by kitchen accidents related to use of kerosene and flammable garments, but also by domestic and intimate partner violence, or even suicide disguised as an accident. In some cases, burns could be linked to dowry-related violence.

6. Sexual and reproductive health and gender norms

Sexual and reproductive health is of critical importance for adolescent health and wellbeing and for a successful transition into adulthood. Data, however, paint an alarming picture: more than [18 million adolescent girls](#) give birth every year in LMICs. Complications in pregnancy and childbirth are a leading cause of female adolescent mortality.

[Twenty million girls](#) aged 15–19 in LMICs have an unmet need for modern contraception. [Nearly half](#) of pregnancies among this age group are unintended and some [3.9 million girls](#) have unsafe abortions. Girls are also highly vulnerable to STIs and [HIV](#): in 2017, they accounted for two thirds of all new HIV infections among adolescents. In sub-Saharan Africa they were three times more likely to be infected than boys, while boys accounted for most of the new infections among adolescents in East Asia and the Pacific, Latin America and the Middle East and North Africa.

A growing body of literature on adolescent sexual and reproductive health has identified some key problems, with limited access to sexual education, lack of youth-friendly services and traditional norms about sexuality and procreation identified consistently as [key barriers](#) that compromise the sexual and reproductive health of adolescents. These barriers operate at all levels from the individual to the health system, and affect both the supply of and demand for relevant services.

Adolescent sexuality and sexual activity outside marriage remain taboo issues in many countries. While adolescents have the right to access accurate information, make informed choices and use quality services, [laws](#) may still be in place that require their parental consent and adolescent sexual and reproductive health may be a low policy priority. In addition, parents, teachers, faith leaders and health workers are often [uncomfortable about discussing such](#)

[issues](#) or about supporting the access of youth to the information and services they need, assuming that talking about sex encourages it.

Adolescents themselves report their own [reluctance](#) to access services because of a lack of privacy and confidentiality, the judgemental attitudes of health providers, and fear of stigma and humiliation. As a result, adolescents often start to engage in sexual activity [without understanding the risks involved](#) and without any accurate knowledge about safe sex and the prevention of pregnancies and STIs. Those belonging to [sexual minorities](#) face increased difficulty, especially where laws criminalise same-sex sexual activity.

The role of gender norms in shaping sexual and reproductive health outcomes has long been recognised in research. There has been a focus on adolescent girls and young women who bear the brunt of inadequate policy and programming, particularly within contexts of persistent gender inequality that deny girls their legitimate right to understand and control their bodies and their life choices.

Norms about feminine behaviours

Studies confirm that the sexual activity of girls is particularly condemned in many LMICs where purity is a key characteristic of adolescent femininity, with girls expected to refrain from sexual activity until marriage. Norms about female purity can stop girls accessing information and learning about their bodies, puberty and sexuality. A review of [knowledge and experiences of puberty and menstruation](#) among young adolescent girls in LMICs found that they tend to have limited knowledge and poor understanding of menstruation, develop negative emotions about it and try to conceal it, citing a study from Jordan in which girls shared they believe that talking about menstruation is socially unacceptable.

Girls who appear to know too much, fail to keep boys at a distance, or act in a sexual way can [ruin their own reputation](#), be labelled as 'bad girls', and even face harassment and shaming. To avoid such risks, girls may have to cover up their changing bodies as soon as they reach puberty. Their movements may be constrained and their social interactions closely monitored by parents and brothers to maintain family honour. To ensure their purity, parents may marry them off at an early age without allowing them any say in that decision.

Married girls are often expected to start childbearing and they have limited decision-making power over their sexual activity within marriage or family planning. Husbands and partners (and in some cases, mothers-in-law) may dominate such decisions, with little involvement of the girls or women concerned.

Evidence shows that [communication with a partner](#) is important if a woman is to achieve her fertility preferences. Young women who have difficulty communicating with their husbands are less likely to use contraception or more likely to conceal its use. Male partners may also restrict contraceptive use and the fear of violence may leave women without much choice. Indeed, [data from 45 countries](#), mostly in sub-Saharan Africa, show that only 52% of women of reproductive age who are married or in a union make their own decisions about sexual relations, contraceptive use or health care. In contrast, [research in urban India](#) found a significant and positive link between gender equitable attitudes among men and contraceptive use.

The paradox is that contraception may also be seen as the woman's responsibility, with unmarried girls engaging in sexual activity often left alone to deal with any unplanned pregnancy or with a STI. Where there is social disapproval of any premarital sex, girls may encounter [judgemental attitudes or mistreatment](#) from health providers and face social stigma for being immoral and dishonouring their families. Girls experience far greater sanctions about their sexual behaviour and report facing [stigma from health providers](#) more frequently than young men.

Fear, limited knowledge, lack of resources or services and discriminatory laws often prompt girls to resort to informal practitioners and dangerous practices to end a pregnancy or deal with a sexual problem. The relationship between pregnancy and access to safe abortion is also influenced by gender norms, with abortion being a highly stigmatising practice in many contexts. An [ALIGN-commissioned annotated bibliography](#) on safe abortion and norms provides key resources that explore various aspects of this topic and identifies existing evidence gaps.

Obedience and submission to male authority are two other features that are typical of traditional femininity with, once again, harmful implications for the sexual and reproductive health of adolescent girls and young women. Even when they are aware of the need for safe sex and the prevention of an unplanned pregnancy, they may be unable to protect themselves. Studies have shown that in settings characterised by unequal gender relations, [girls have limited ability to negotiate condom use](#) as they may be seen as unfaithful or promiscuous, or face partner violence and sexual coercion that increase their vulnerability to unwanted pregnancies, STIs and HIV.

Research in countries in sub-Saharan Africa with high HIV rates among young women has noted that unequal gender norms promoting male dominance limit women's ability to control their sexual relationships and ask men to use condoms. One study in [Botswana and Eswatini](#) found that women's greater adherence to unequal gender norms was associated with limited control over their own sexual health and their sexual activity with much older men.

The intersection of gender with age and poverty increases female vulnerability. Young women with much older partners and those who are economically dependent on men find it more difficult to negotiate safe sex practices. [Evidence from Southern Africa](#) shows that women with partners who are ten or more years older than them, those who are abused and those who are dependent on their partners are less likely to suggest condom use. Similarly, [survey data](#) from 24 countries in sub-Saharan Africa show that rates of condom use are very low during high-risk sex by women in the lowest wealth quintile and those who have no formal education.

Norms about masculine behaviours

While rigid gender norms have significant implications for the health and lives of adolescent girls, they also affect adolescent boys. Masculine norms about taking sexual risks, having many heterosexual partners, engaging in sexual intercourse as proof of manhood or avoiding health care, leave boys [vulnerable to sexual risks and infections](#), and contribute to [poor sexual and reproductive health outcomes](#).

With the onset of puberty, girls and boys often have to follow different rules about 'acceptable' engagement in intimate and sexual relationships. Known as the [sexual double standard](#), this set

of norms expects girls to show modesty and maintain their purity, while boys are encouraged to engage in sexual activity to live up to masculine ideals and prove their sexual prowess.

According to [such ideals](#), sexual intercourse is an act of conquest and an affirmation of masculine power – and one that rejects intimacy and emotional bonding as feminine qualities. Boys are often [socialised](#) to the idea that the male sexual drive is biologically determined, uncontrollable and must be satisfied through the conquest and submission of girls, legitimising forced sexual intercourse. Norms that equate masculinity with risk-taking also prompt men to avoid safe sexual practices, including condom use. Research in [Ethiopia](#) has concluded that unmarried adolescent boys and young men with friends who have used condoms are more likely to use condoms themselves.

Boys often feel [pressured](#) to live up to masculine expectations endorsed by their male peers and display their virility to build their reputation and avoid ridicule, including homophobic comments. Traditional gender norms promote heterosexuality, leading to homophobia and stigmatisation of same-sex relations, and boys who do not align themselves with aggressive heterosexual norms face greater sanctions than girls with alternative sexual identities.

Similarly, communication with partners and joint decision-making are not considered appropriate for ‘real men’. Studies have shown that [greater adherence to inequitable gender norms](#) is associated with increased male-controlled sexual decision-making, perpetration of rape, unprotected sex and multiple sex partners for men.

Adolescent boys may also think that they should appear to know everything, even though they often have inadequate information about sexual health. Norms that promote male strength and self-reliance may discourage them from seeking information or help. As well as norms that disapprove of adolescent sexual activity and shape negative attitudes from health providers, gender norms may prompt boys to avoid or delay seeking medical assistance such as STI testing and treatment. Greater adherence to inequitable gender norms has been [linked to lower levels](#) of HIV testing and health-seeking.

7. Mental health and psychosocial wellbeing and gender norms

Adolescent mental health and psychosocial wellbeing are gaining greater recognition as public health concerns. [Mental health problems](#) account for 16% of the global burden of disease and injury among adolescents, with depression being the leading cause of illness and disability, and suicide one of the leading causes of death among older adolescents, in particular. Although adolescence is considered a relatively healthy period in the life-cycle, many common mental health disorders, such as depression and anxiety, start at this time and continue into adulthood, with serious consequences for an individual’s health and life. Experts note that [biological, emotional and cognitive processes interact with environmental factors](#) during this period and can lead to mental health problems.

[Gender differentials](#) that characterise adult populations emerge during adolescence. Although accurate data are scarce in many countries, girls are between 1.5 and 2 times more likely than boys to be diagnosed with depression. In general, they have a higher prevalence of depression and are more likely to have suicidal thoughts and engage in self-harm than boys. Yet boys die more frequently as a result of suicide, with a few country exceptions. [India](#) is one such

exception, with suicide the leading cause of deaths among adolescent girls and young women, with married women accounting for the highest proportion in 2016.

[WHO](#) recognises that rigid gender norms, roles and responsibilities can increase vulnerability to mental health risks and have negative implications for the psychosocial wellbeing of women but also of men. In contexts characterised by gender inequality, young women often experience limited mobility, autonomy and decision-making power, are highly vulnerable to discrimination and violence, and are expected to submit to male authority. Men, meanwhile, are expected to take risks, repress their emotions and demonstrate toughness and independence.

Norms about feminine behaviours

Gender norms and expectations have serious implications for adolescent girls and young women. [Evidence from diverse settings across LMICs](#) shows that lack of control over their life and of parental support, weak peer and social relationships, and exposure to violence (particularly sexual abuse), lead to poor psychosocial wellbeing, as well as suicidal behaviour.

Indeed, [puberty increases girls' exposure](#) to factors that contribute to their mental health problems. Where norms emphasise female purity and related family honour, adolescent girls face significant restrictions and are vulnerable to early marriage. Studies have also examined the links between violence and mental health and have concluded that violence is a major contributor to mental health problems.

[One global study](#), for example, estimated that women who have experienced intimate partner violence are almost twice as likely to experience depression as those who have not. Evidence from contexts with high rates of gender-based violence and early marriage reinforce this finding. A [recent study in rural India](#) found high levels of psychological distress among young low-caste adolescent girls and identified its strong associations with sexual harassment and abuse, school dropout and early marriage, with one third of girls reporting that they had no hope for the future.

Similarly, [research in Ethiopia](#) found that girls who had ever been married, promised in marriage or had received marriage requests were far more likely to have had suicidal thoughts than those who had not been involved in any marriage process; indeed, the likelihood of suicide attempts among those with marriage requests were twice as high.

In contrast, positive family and peer relationships, staying in school and having some control over one's life in line with one's evolving capacities all serve as protective factors. An [ALIGN-commissioned piece](#) provides comprehensive information about how gender norms drive psychosocial distress among girls and identifies promising initiatives for its mitigation.

Norms about masculine behaviours

[Traditional masculine norms](#) require that men show resilience in the face of adversity, tolerate pain, manage negative emotions and refrain from seeking help. Any inability to abide by these norms is viewed as a sign of weakness that is equated with femininity. The popular saying 'boys don't cry' is a common expression of such norms, guiding boys to hide their fear or sadness and deal with such feelings alone. Evidence confirms that where masculine self-reliance is promoted, young men are often reluctant to seek psychological help and may resort to negative coping strategies such as social withdrawal and substance abuse to deal with their emotional pain.

A large body of literature shows that conformity to traditional norms contributes to poor mental health outcomes for men. A study with a representative sample of young men in [Mexico, the UK and the US](#) identified strong links between adherence to rigid masculine norms and mental health problems; in all three countries men who did what was expected of them were far more likely to report depressive symptoms, including suicidal thoughts, than peers who held more equitable gender attitudes. Not only can conformity to traditional norms contribute to distress, but it also inhibits men's access to services and treatment: a systematic [review](#) noted that this conformity affects their ability to recognise and communicate symptoms of depression, their intention to seek help, the way in which they seek help and the effectiveness of any treatment.

Norms, sexuality and psychosocial wellbeing

Adolescents and youth whose sexual orientation does not conform to traditional gender norms often face [increased stigma and discrimination](#), gender-based violence and exclusion. Studies also report an [increased risk of mental health problems](#), including anxiety, depression and substance use. Evidence from LMICs is limited, but a [study in Viet Nam](#) found that over 70% of LGBT students experienced physical and verbal abuse in school, with almost a quarter reporting suicidal thoughts and 15% having attempted self-harm or suicide.

8. Health systems and gender norms

Health systems, including their workforces, institutions and resources, are expected to provide quality services to all people in a timely and efficient way. However, as part of the wider context in which they operate, [health systems are not gender neutral](#). On the contrary, they [reflect and reproduce](#) established gender norms, thereby contributing to gender inequities in health and in society at large. There are two main pathways through which this shapes health outcomes for young women and men: the first relates to service delivery and provider-patient interactions; and the second to the involvement of men and women in health care provision – both formal and informal.

Norms and health service delivery

[Health systems](#) often overlook gendered power relations that shape gender differentials in health needs and outcomes and, as a result, they fail to plan and provide appropriate services. [Gender norms](#) can influence whether health systems and their providers recognise a condition as a health problem and provide the appropriate treatment. For example, chronic pain or depression among women is often normalised, and domestic violence is not always considered an issue that demands a health response.

Health providers and systems may also [discourage](#) the active involvement of men in maternal and child care. An [analysis of demographic and health survey \(DHS\)](#) data from 36 countries found that men's presence at prenatal care visits reached or exceeded 60% in only six of them. Even when men want to support and accompany their partners, they may be discouraged to do so as childbirth is still considered '[women's business](#)' in some contexts.

Health systems may also pay [insufficient attention to gender gaps](#) in access to services and, as a result, fail to make appropriate provisions. They may not recognise, for example, that the ability of low-income women to access care is compromised by their limited financial resources, weak decision-making power or heavy domestic workload. Health systems may also

overlook the critical role of gender norms in shaping women's mobility and social interactions and fail to plan accordingly. In settings characterised by conservative norms and gender segregation, lack of female health providers becomes a barrier for girls and women's access to health services, as any interaction with men, let alone physical contact or the examination of private parts, violates what is deemed acceptable and harms female reputation and family honour.

The gendered attitudes and behaviours of health providers in their interactions with patients also shape patients' access to, and use of, health care. Where female sexuality is only acceptable within marriage, the judgemental attitudes of health workers can discourage unmarried girls and women from accessing sexual and reproductive health services.

Studies from various settings point out that in adolescents, in particular, are afraid of [providers' attitudes towards premarital sexual activity](#), while health workers also find it difficult to provide information and services to them. Such attitudes compromise efforts to prevent or deal with STIs or unwanted pregnancies, prompting girls to resort to informal providers and unsafe practices that contribute to obstetric complications and maternal mortality.

Fear of (or actual) mistreatment during childbirth makes women reluctant to access professional care. A [systematic review](#) found that physical and verbal abuse of women by health providers was reported across all regions, together with stigma and lack of privacy and confidentiality. Women from different ethnic backgrounds, unmarried girls and women, and poor women often report greater stigma and discrimination. [Single mothers](#) seeking maternal services in public health facilities, in particular, can face stigma and abusive treatment.

Disrespectful comments, discriminatory attitudes and even denial of treatment are accentuated in the case of groups who transgress gender norms and face increased vulnerability, such as [sexual minorities](#). Negative experiences in service provision may deter them from seeking care in health facilities: in [Argentina](#), 67% of young transgender women reported having faced discrimination from health workers and 32% by other patients, with those who have had negative experiences being three times more likely to avoid using health services than those without such experiences.

Norms and the health workforce

Gender norms do not only shape the attitudes and behaviours of health providers and their interactions with service users: they also shape the structure and hierarchies of the health workforce and compromise the development of effective and equitable health systems.

Gender norms and stereotypes about what women and men can do influence their participation in the health workforce. In essence, [they may not have equal chances](#) of entering a health profession, acquiring the necessary skills, getting a job, and enjoying equal payment, training and progression opportunities because gender norms shape their education, employment and professional experiences.

Women account for [the majority of the global health workforce](#), which is nevertheless characterised by horizontal and vertical occupational segregation. In many settings, they comprise the majority of nurses, community health workers and midwives, while men dominate jobs seen as requiring 'higher' skills in health delivery and management positions. [Nursing](#), for example, has been linked traditionally to the maternal instinct of caring and has, therefore,

been considered less of a specialised profession but rather a 'natural' feminine characteristic. Analysis of [data from Kenya](#) identified differences among female and male students, with nursing, nutrition and community health work being seen as 'women's work' and jobs in pharmacies seen as considered 'men's work'.

The number of men studying nursing is, however, increasing, challenging the norms that associate women with caregiving roles and that label those doing 'women's work' as less masculine. In addition, [women's participation](#) in medical schools is increasing, although they are often less likely than men to practise medicine once they are trained and more likely to practise medicine, gynaecology or paediatrics than surgery or other well-paid specialties. In [Rwanda](#), 47% of male junior medical students reported surgery as their first speciality preference, compared to just 20% of their female counterparts.

As well as affecting education and employment patterns, gender norms also influence [the work experiences and opportunities](#) of health workers, including the pay and benefits they receive and that are necessary to ensure a competent and productive health workforce for the delivery of quality care. [Evidence from health facility surveys](#) in six LMICs shows that women nurses and midwives are far less likely than their male counterparts to have accessed training.

In addition, women often receive lower wages – a [global review of data](#) from 20 countries found that one additional percentage point in the rate of women in one health occupational group is associated with an 8% decrease in its wage rank on a scale from 16 to 1, a clear indication of women's skills and occupations being de-valued as 'female'. Women health workers are also more vulnerable to [workplace violence](#) and abuse: in [Rwanda](#) they accounted for three quarters of the health workers who reported being sexually harassed at work. Family responsibilities and related norms also hinder women's ability to access training or advance their health careers, with women over-represented in general practice and other medical occupations that allow for more flexible arrangements.

Women also comprise the vast [majority of unpaid care workers](#) for family members with chronic medical conditions or disabilities. Such work can be physically and emotionally demanding, with a negative impact on caregivers' physical and mental wellbeing, while also limiting the opportunities of women and girls for education and employment. Despite their crucial contributions as they cover the gaps left by formal health care, their caregiving work is often undervalued and taken for granted as part of their domestic responsibilities. Yet [estimates](#) indicate that the average annual value of women's unpaid contributions to health accounts for between 2.27% and 2.43% of global GDP.